KANSAS DEPARTMENT FOR AGING & DISABILITY SERVICES

Application For
REINSTATEMENT OF KANSAS DIETITIAN LICENSE

A Kansas dietitian license may be reinstated upon meeting requirements of K.S.A. 65-5909 and K.A.R. 28-59-5a. Please complete this application documenting at least 15 hours of continuing education, return it with completed information inventory, proof of your social security number, and appropriate reinstatement fee.

License Number:_____ Social Security Number:_____

Name:_____
Last First Middle (Other name(s) used)

Address:_____

Work Phone: (____) _____ Home Phone (___)_____

Record program approval number if program was prior approved, program title, date, and total clock hours per program in the appropriate column. Submit verification of attendance for all prior approved programs listed.

KDADS Approval Number *ONLY required if program was prior approved.*	Program Title	Program Date	Clock Hrs

(Use additional paper if needed)

(Please complete the remainder of the application on the back of this page)

LICENSE IN ANOTHER STATE

List all states in which you have ever held a dietitian license:

State: _____ State: _____ State: _____

State: _____ State: _____ State: _____

For each state, complete Part I of the *Verification of License*, request that the state board complete Part II and return verification to KDADS.

Disciplinary Action—This information is required under Kansas law: KSA 65-3503(a)

Has any license, certification, or registration issued by Kansas or another state or entity been denied, refused for renewal, suspended, revoked or subjected to any other disciplinary action? **Y/N**

If YES, please explain:

_____

_____

_____

Have you ever been convicted of a crime by any court (including Kansas), or any federal court of the United States? **Y/N** If YES, please indicate:

Date of Conviction: _____

City, County and Sate of Conviction: _____

Crime of which convicted: _____

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided in this application and attachments. I understand that the application fee is non-refundable should I not meet licensure qualifications.

☞ **NOTE: Applicant signature must be notarized.**

_____ _____

Signature of Applicant Date

SUBSCRIBED AND SWORN TO before me, the undersigned authority, on this _____ day of _____, 201_____

_____

(Notary Public Signature)

My appointment expires: _____

Submit applications, supporting documents and fee to:

Health Occupations Credentialing
612 S Kansas Ave
Topeka KS 66603